MEDICAL RELEASE FORM

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I,_____ (parent/guardian's name) hereby give permission for any and all medical attention to be administered to my child _____ (child's name) in the event of accident, injury, sickness, etc., under the direction of the physician(s) listed below or at any necessary emergency facility, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS:_____

_____

HOME PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER:_____

CHILD'S PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES:_____

SIGNATURE (PARENT/GUARDIAN) _____

DATE _____